

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264		X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/16/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/16/11</p> <p>Facility Number: 000165 Provider Number: 155264 AIM Number: 100288220</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Golden Rule was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The facility consists of the original building built in 1973, a one story sprinklered building of Type V (000) construction, and the south portion of the building constructed in 1983, including the South Wings and Medicare Suite Wing, a one story sprinklered addition of Type V (111) construction. The original</p>			K0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and comply with all applicable State and Federal regulatory requirements.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2011

FORM APPROVED

OMB NO. 0938-0391

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K0029 SS=E	<p>building and South Wings are separated by a two hour fire barrier wall. Because the original building and the addition are different types of construction, the facility was surveyed as two buildings.</p> <p>The building is provided with complete sprinkler protection. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 170 and had a census of 137 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/23/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following</p> <p>Based on observation and interview, the facility failed to ensure the 2 of 24 corridor doors to hazardous areas, such as soiled linen rooms, were provided with doors equipped to self close, and automatically close and latch into the door frame. This deficient practice affects 12 residents who reside on the Alzheimer/Acute Care Hall.</p>			K0029	<p>The 2 corridor doors identified on the 2567 were installed with self closure devises on 3-17-11. An inspection of all doors opening to the corridors that require self closing devises was done on 3-17-11 with no other doors identified as non-compliant. Compliance will be maintained and monitored through the preventative maintenance process.</p>		03/17/2011

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	Findings include: Based on observation on 03/16/11 at 11:55 a.m. with the Lead Maintenance Technician, the Alzheimer/Acute Care Hall soiled linen room, where four containers of soiled linen were stored, had a door lacking a self closing device leading to the Alzheimer/Acute Care Hall and another door lacking a self closing device leading to the Alzheimer/Acute Care Unit Hall. This was verified by the Lead Maintenance Technician at the time of observation. 3.1-19(b)						
K0062 SS=F	Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected internally every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.1. This deficient practice affects all			K0062	An internal pipe inspection for the sprinkler system will be completed by 4-15-11. The Maintenance Supervisor will track inspection dates for compliance. The E.D. will monitor through the QA committee.		04/15/2011

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	residents in the facility. Findings include: Based on review of Internal Pipe Inspection Reports with the Lead Maintenance Technician on 03/16/11 at 10:20 a.m., the last Internal Pipe Inspection Report was dated 08/02/05, which was a period exceeding the five year requirement. Based on an interview with the Lead Maintenance Technician and Administrator on 03/16/11 at 10:40 a.m., an estimate was obtained for the internal pipe inspection but it has not been conducted yet. 3.1-19(b)						